MINNESOTA BOARD OF MEDICAL PRACTICE

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VERIFICATION OF POSTGRADUATE MEDICAL TRAINING

(Copy this form for multiple programs)

This form is for verification of all US/Canadian post graduate medical training (i.e. internship, residency and fellowship) and must be completed and mailed by the facility DIRECTLY to the **Minnesota Board of Medical Practice**. The applicant's signature authorizes release of information, favorable or otherwise, DIRECTLY to the Board.

Print Name_____ SS#_____

Signature _____ Date_____

Training Dates (Month,Day,Year)_____ Birthdate_____

This section is to be completed by the Program Director or Graduate Medical Education Representative

It is hereby certified that:(Name of Applicant)_____

Received credit for post graduate training:(# Months)_____ from date:____/____/_____to date:____/____/_____

The program was accredited to provide graduate, clinical, medical training during the dates above by: (Check One)
ACGME___ AOA___ RCPSC___ CFPC___ None of the above___ (explain)_____

at:(Name of Hospital or Institution)_____

located at_____
(Street Address, City, State, Zip, Country)

Affiliated Medical School Name_____Specialty_____PGY_____

Training Program (Check One): Internship____ Resident____ Chief Resident____ Fellowship____ Research____

Did the applicant complete all required years of the post graduate training program?
Program was completed ___ Anticipated date of completion____/____/_____

___Program was not completed because_____

Was this individual issued a certificate as proof completion of training? …… Yes ☐ No ☐

Did the individual take a leave of absence or break during training? …….. Yes* ☐ No ☐

Was this individual ever placed on probation or remediation?…… Yes* ☐ No ☐

Was this individual ever disciplined or placed under investigation? ..... Yes* ☐ No ☐

Were any limitations or special requirements placed upon this individual due to academic incompetence, disciplinary problems or any other reason? …….. Yes* ☐ No ☐

Institutional Seal

If the institution does not have an official seal, the form must be notarized.

Completed by Program Director or Graduate Medical Education Representative:

Print Name_____

Signature_____

Date_____ Phone_____

Fax_____ Email_____

*Attach letter of explanation

1/2011